



Texas Department of Insurance, Division of Workers' Compensation  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:

Summit Rehabilitation Centers  
2420 E. Randol Mill Rd.  
Arlington TX 76011

MFDR Tracking #: M4-07-7858-01

Respondent Name and Box #:

FEDEX GROUND PACKAGE SYSTEM IN  
BOX 22

Diagnosis

Injury

Date

Employer

Insurance

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Provider sent a request for reconsideration on June 8, 2007. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$2,343.08
3. CMS 1500s
4. EOBs
5. Preauthorization Letter

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

No Position Summary was received from the Respondent.

Principal Documentation:

1. Response to DWC 60

### PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
9-12-06 – 9-18-06	97545-WC (\$28.80 x 6 units)	No EOB	1, 4, 6	\$172.80
9-12-06 – 9-18-06	97546-WC (\$28.80 x 18 units)	No EOB	1, 4, 6	\$518.40
9-22-06 – 9-25-06	97545-WC (\$28.80 x 4 units)	W9, W1	2, 4, 5, 6	\$115.20
9-22-06 – 9-25-06	97546-WC (\$28.80 x 11 units)	W9, W1	2, 4, 5, 6	\$316.80
9-26-06 – 9-29-06	97545-WC (\$28.80 x 8 units)	62, W1	3, 4, 6	\$230.40
9-26-06 – 9-29-06	97546-WC (\$28.80 x 24 units)	62, W1	3, 4, 6	\$691.20
10-02-06	97750-FC (\$37.31 x 8 units)	62, W1	3, 7	\$298.48
<b>Total Due:</b>				<b>\$2,343.28</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

The Amount Sought in Part II, 2 and the Total Due Amount do not agree because the Requestor made an error in his calculation on the Table of Disputed Services.

1. Neither the Respondent nor the Requestor provided EOB's for these services. The Requestor submitted convincing evidence of carrier receipt for "Request for EOBs" in accordance with 133.307(e)(2)(B). This review will be according to Rule 134.202.
2. The Respondent denied these services as "W9- Unnecessary medical treatment based on a peer review," and "W1- Workers Compensation State Fee Schedule Adjustment."
3. The Respondent denied these services as "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," and "W1-Workers Compensation State Fee Schedule Adjustment."
4. The Requestor provided a copy of a Preauthorization Letter dated 8-30-06 for "10 days of Work Conditioning."
5. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Per Rule 134.600 (c)(1)(B) "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care."
6. Recommend reimbursement per Rule 134.202 (e)(5)(B)(ii) at \$28.80 per hour.
7. Per Rule 134.600 these services do not require preauthorization. Recommend reimbursement per Rule 134.202 (c)(1).

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule 134.600 (c)(1)(B).

#### PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311  
28 Texas Administrative Code Section. 134.1, Section. 134.202  
Texas Government Code, Chapter 2001, Subchapter G

#### PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$2,343.28 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

#### ORDER :

  
Authorized Signature

  
Medical Fee Dispute Resolution Officer

9-27-07  
Date

#### PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. Please include a copy of the Medical Fee Dispute Resolution Findings and Decision together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[REDACTED]

[REDACTED]